

COVID 19: A global health problem from the perspective of obstetricians

Covid 19 and pregnancy

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To the editor:

Coronavirus disease 2019 (COVID-19) has become a global health problem threatening billions of people worldwide. Severe acute respiratory syndrome is caused by a new coronavirus called coronavirus 2 (SARS-CoV-2). Although antiviral treatment has been performed, there is currently no effective cure or vaccination [1]. People with concomitant medical diseases such as diabetes or hypertension, congenital or acquired cardiac disease history, cancer patients, severe respiratory illness such as cystic fibrosis or advanced asthma, chronic liver or kidney disease, those with a history of congenital metabolic diseases such as sickle cell anemia and the presence of the use of immunosuppressive drugs are more vulnerable to this disease [2]. The current literature on the course of the disease during pregnancy and on mortality and morbidity during pregnancy is limited. There is no evidence of an increased rate of miscarriage or early pregnancy loss in pregnant women with COVID-19. Besides, the fact that SARS and MERS infections, which have been shown in previous studies, are not associated with complications such as miscarriage and early pregnancy loss strengthens this hypothesis [3].

In pregnant women, as in adult patients, 85% of cases may have pulmonary findings in the acute period. The ground glass image with multilobar involvement is typical. In prolonged cases, the image becomes clear in the lower lobes. Lesions may be distributed in the periphery, reticular opacities, and vascular thickening can be observed. In cases that are not severe, there may be no findings on the tomography. Tomography may be more sensitive in suspected patients with a negative RT-PCR test. Also, the lungs can be evaluated using a 3.5 MHz convex ultrasound probe. Thoracic ultrasonography is easy to apply, does not contain radiation, and is easy to sterilize. Due to its bedside applicability, it can be used in the first triage by experienced people in light and stable cases. With the COVID-19 pandemic, it is of great importance to reduce the frequency of antenatal follow-up as much as possible, especially in crowded environments such as hospitals. Examinations such as the 1st-trimester screening test and 2nd level ultrasound scanning should not be neglected. While the frequency of follow-up is reduced, patients should be informed about the necessity of following the fetal movements and obstetric emergencies. Besides, it should be explained that the symphysis pubis-fundus distance should be monitored, and in cases where it does not increase sufficiently, adverse pregnancy outcomes may accompany, and the doctor should be informed that it should be consulted earlier. The latest data indicate that there is no vertical transmission to the fetus, and no virus has been found in the cord blood of newborns born to COVID-19 positive pregnant women, nasal sampling, and amniotic fluid and placenta of pregnant women [4].

Suspected or possible cases should be followed in isolated rooms and confirmed cases in negative pressure rooms, and this treatment should be done in tertiary hospitals. If there is no negative pressure room, suspicious/possible patients should be followed in isolated places, and cases with COVID-19 should be followed in shared rooms. In countries where clinically mild, asymptomatic pregnancy is common, and health institutions do not have sufficient capacity, it is appropriate to protect family members and keep them under quarantine at home. In mild cases, it is necessary to ensure the fluid-electrolyte balance and carry out symptomatic treatment. Based on current data, antiviral therapy is not recommended in mild cases. For bacterial infections (blood, urine culture), monitoring should be done. If a secondary infection develops, antibiotherapy should be started at an appropriate time. Both maternal and fetal mortality rates are high in cases with severe pneumonia. In addition to aggressive treatment, oxygen therapy and hydration should be given. Pregnant women should be followed up and treated by multidisciplinary teams in negative pressure rooms, if possible, in intensive care units. Blood pressure monitoring, appropriate O₂ saturation and fluid balance should be provided. Low molecular weight heparin should be used for severe cases, as microthrombi develop in addition to macroscopic hemorrhages in the liver and lungs. Severe cases should be evaluated by a multidisciplinary team below the 32nd gestational week, and if the decision to give birth is to be made, it should be made by that team. If the labor cannot be delayed in a pregnant woman with suspected COVID-19, delivery should be performed by providing protective measures. The minimum possible number of people should be involved in the surgery. Regarding its effects during labor, it has been stated that fetal distress is seen at a higher rate during labor. Therefore, if vaginal delivery is planned in these patients, continuous electronic fetal monitoring is considered more reliable [5].

References:

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